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**MedPAC Recommendations on  
Implementing Medicare Provisions  
of the Balanced Budget Act of 1997**

Gail R. Wilensky, Ph.D  
Chair  
Medicare Payment Advisory Commission

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U.S. Senate

Good morning Chairman Roth, Senator Moynihan, and members of the Committee. I am Gail Wilensky, Chair of the Medicare Payment Advisory Commission (MedPAC, or the Commission). I am pleased to be here this morning to discuss the provisions of the Balanced Budget Act (BBA) of 1997 that affect the Medicare program and how they are being implemented. My testimony will draw heavily on MedPAC's Report to the Congress on Medicare Payment Policy, which was released March 1.

Broadly speaking, the Commission's recommendations address four topics: adequacy of payment updates, equity of payments, technical and regulatory components of new payment mechanisms, and other payment-related issues concerning coverage and beneficiary cost sharing.

For certain services whose payment updates are set in law by the BBA—such as those provided by Medicare+Choice plans, inpatient hospitals under the prospective payment system (PPS), and physicians—MedPAC's recommendations address whether the statutory updates are appropriate. In general, the Commission finds the updates to be appropriate and does not recommend changes to the law. In the case of payment for physicians' services, however, the Commission has developed several recommendations.

For example, the sustainable growth rate mechanism should account for changes in medical technology and changes in the characteristics of beneficiaries enrolled in traditional Medicare, such as their distribution across age groups.

MedPAC's recommendations also address the issue of payment equity. The Commission supports the introduction of a new risk adjustment system for the Medicare+Choice program to make payments that better reflect enrollees' health status. We also recommend changing payment methods for hospital outpatient and physicians' services to account for cost differences that reflect differences in patients' health status.

For services that the BBA directed to be paid under new payment systems, MedPAC addresses recommendations to the Secretary of the Department of Health and Human Services (the Secretary) and to the Congress, as appropriate. We recommend technical changes in regulations that would make payments more equitable within provider groups and more consistent across types of providers. For example, the Commission supports the Secretary's efforts to develop a case-mix adjustment system for skilled nursing facilities that would better account for use of services other than rehabilitation therapy. The Commission also supports developing a common unit of payment—a facility discharge where possible—across providers of post-acute care.

With respect to other issues, MedPAC's key recommendations concern services provided in outpatient hospital departments and by home health agencies. For the former, MedPAC recommends accelerating the so-called coinsurance buydown provided for in the BBA. For the latter, we recommend further clarification in statute eligibility guidelines for receiving home health services.

### **The Balanced Budget Act of 1997 and the Medicare Program**

The Balanced Budget Act made wide-reaching changes to the Medicare program. It established the Medicare+Choice program, which allows new types of private health plans to offer options for Medicare beneficiaries, and changed how Medicare pays private health plans to slow the rate of growth of spending and make payments more equitable among providers and across geographic areas. In the traditional Medicare program, the BBA changed payment updates and methods for services provided by acute care hospitals and physicians. It also directed the Secretary to establish new prospective payment systems for skilled nursing facilities, home health agencies, rehabilitation hospitals, and hospital outpatient departments.

MedPAC is monitoring the implementation of BBA policies closely and evaluating them on the principle that Medicare's payment policies should ensure

beneficiaries have access to necessary medical care in an appropriate setting. At the same time, the program should not spend more than is required to achieve that goal. This principle implies that payment rates must be consistent with the costs of efficiently providing the necessary level of care, while not interfering with clinical decisions as to the amount of care or the setting in which it is provided.

### **Creation of the Medicare+Choice program**

The BBA abolished the so-called section 1876 risk contracting program, which had allowed Medicare beneficiaries to enroll in health maintenance organizations (HMOs). In its place, the Act established a new program called Medicare+Choice, which permits many new types of private health plans to participate in Medicare, including preferred provider organizations (PPOs), HMOs with a point-of-service option, provider-sponsored organizations (PSOs), private fee-for-service plans, and high-deductible plans offered in conjunction with a medical savings account.

The BBA also changed how private health plans are paid. Under the old risk contracting program, Medicare set payments for managed care enrollees in each county at 95 percent of what the program would have paid had those enrollees remained in the traditional fee-for-service program. The BBA broke the direct link between the level of

county fee-for-service spending and Medicare managed care payments. Under the new system, Medicare+Choice plans are paid the higher of a floor rate, a 2 percent increase from the prior year's rate, or a blend of local and national payment rates (but only if a so-called budget neutrality condition is met). The BBA also directed the Secretary to implement a new system of risk adjustment based on the health status of plans' enrollees, effective for payments in 2000.

One of the major objectives of the BBA was to make a wider variety of private health care coverage options available to Medicare beneficiaries by expanding the types of private health plans eligible to participate in Medicare. However, changes in how payment rates are determined, the establishment of new regulations to implement the program, and concurrent trends in the health insurance environment resulted in few new available options and, in fact, a sizable portion of former risk plans declined to participate in Medicare+Choice.

It is too soon to tell whether the recent departures from Medicare stem from systematic problems with the level or distribution of payment. Accordingly, the Congress should not modify payment rates at this time. MedPAC will continue to monitor this situation during the next year. In the meantime, the Health Care Financing Administration (HCFA) should continue to work with the relevant parties to identify

changes in regulations or other policies that would reduce the burden of compliance without compromising the objectives of the program. Two specific changes recommended by MedPAC include postponing the date by which Medicare+Choice organizations must file their premium and benefit proposals and allowing organizations to vary their benefit packages by county within their service areas.

The Commission supports the Secretary's plan to phase in, beginning in 2000, an interim risk adjustment mechanism for Medicare+Choice payments. In this mechanism, differences in expected costliness among enrollees will be based on health status, as measured by diagnoses from hospital stays in the previous year, prior entitlement to Medicare benefits based on disability, and eligibility for Medicaid benefits during the previous year. As quickly as feasible, however, the risk adjustment mechanism should be refined to incorporate diagnosis data from all sites of care. These changes should improve the correlation between payments to Medicare+Choice organizations and the expected service use of their enrollees.

### **Provisions affecting payments to hospitals**

For inpatient services provided in acute care hospitals under the PPS, no update was made to payments in fiscal 1998, and the BBA limited updates for 1999 through 2002 to

the growth in the hospital market basket less a specified factor. For rehabilitation, long-term, and psychiatric hospitals—whose payments had been made on the basis of costs subject to facility-specific limits—the BBA instituted new national cost limits and established more stringent limits for new facilities.

*Hospitals covered by the acute care prospective payment system.* Based on our ongoing analysis of the factors that determine year-to-year changes in hospital costs, we believe the operating update for fiscal year 2000 that was enacted in the BBA—1.8 percentage points less than the increase in HCFA’s hospital operating market basket index—will provide reasonable payment rates. If the current market basket forecast holds, the update would be 0.7 percent.

MedPAC’s analysis shows that hospitals have responded to a more competitive market by improving their productivity and shifting services to other sites of care. These two responses have resulted in a substantially lower rate of inpatient cost growth and sharply higher Medicare inpatient margins. Although both Medicare and the industry benefit from productivity improvements, the site-of-care substitution has increased Medicare’s payments. When post-acute care replaces the latter days of inpatient stays, Medicare picks up an additional payment obligation while its per-case payment for hospital care is unchanged.

MedPAC believes that a downward adjustment to payments is warranted to account for site-of-care substitution. Part of this adjustment was reflected in the update recommendation we made last year for fiscal 1999, and in our predecessor commission's recommendation for fiscal 1998. But we currently believe that an additional adjustment of between 3 and 6 percentage points should be made. To avoid too great a single-year impact, the adjustment should be spread over three years.

At the same time, however, several factors point toward the need for caution in specifying future updates. First, the expanded transfer policy included in the BBA should be considered part of Medicare's response to site-of-care substitution, and its effects are not yet known. Second, evidence is emerging that the decade-long trend of cases shifting towards higher-weighted diagnosis-related groups, which automatically increases PPS payments, is subsiding. Third, we question whether the unusually low rate of hospital cost inflation in recent years can be sustained without adverse effects on quality of care. The year 2000 computer problem will also put upward pressure on hospital costs. And finally, several provisions of the BBA will reduce Medicare's payments for other hospital services, and the overall impact of the BBA on hospitals is not yet evident.

The BBA also phased in a 5 percent reduction in Medicare's extra payments to

hospitals that care for a disproportionate share of low-income patients, increasing the importance of allocating these payments appropriately. Currently, disproportionate share payments are made through a complex formula that determines a percentage add-on to each hospital's PPS payments based on its location, size, certain other characteristics, and a measure of care to low-income people. The measure of care to low-income people, however, excludes uncompensated care and local indigent care programs, which represent a large share of the burden faced by many hospitals that treat low-income patients. Moreover, under the current formula, rural and small urban hospitals that treat a disproportionate share of low-income patients receive a much smaller adjustment (if any) than large urban hospitals with the same share. Our technical recommendations are intended to eliminate these flaws.

*Facilities exempt from the acute care prospective payment system.* Certain types of hospitals and distinct units of hospitals are exempt from the acute care PPS. These so-called PPS-exempt facilities are a diverse group that share a common Medicare payment method established by the Tax Equity and Fiscal Responsibility Act of 1982. They include rehabilitation, long-term, psychiatric, children's, and cancer hospitals, and rehabilitation and psychiatric units in acute care hospitals. Each of these facilities is paid an amount based on its own costs in the payment year relative to a per-case target that depends on its costs in a base year, updated to the payment year.

MedPAC's analysis of the factors that determine year-to-year cost increases for PPS-exempt facilities indicates that the update factor applied to the per-case targets in fiscal year 2000 should be increased by 0.4 percentage point more than in the formula prescribed in the BBA. The BBA also established a category-specific cap on the per-case targets for rehabilitation and psychiatric facilities and long-term hospitals but did not provide that these nationwide caps be adjusted for differences in input prices across areas. We recommend correcting that technical oversight.

The BBA required that Medicare implement a new payment system for rehabilitation facilities and that the Secretary develop a proposal for long-term hospitals. It did not mention psychiatric facilities, however. MedPAC encourages additional research in case-mix classification for payments to psychiatric facilities, with an eye toward developing a PPS for them in the future.

### **Provisions affecting payments to physicians**

The BBA mandated a number of changes in the Medicare Fee Schedule for physicians. To update payment rates for physicians' services, a sustainable growth rate system was established to replace volume performance standards. To make the fee schedule fully resource based, HCFA recently began to phase in a new methodology for the practice

expense component (which it intends to refine as it is used) and is developing revisions to the professional liability component.

MedPAC recommends several modifications to the sustainable growth rate system (SGR). These include revising the SGR to include measures of changes in demographic and other characteristics of Medicare fee-for-service enrollees, to reflect cost increases due to desirable improvements in medical capabilities and scientific technology, and to correct for inaccuracies in estimates used in SGR system calculations. We also call for a reduction in time lags between the periods on which the various components of the SGR are based and the earlier availability of estimated updates for each upcoming year.

With respect to HCFA's implementation of resource-based practice expense payments, MedPAC agrees that, for some services, it is appropriate to pay a lower practice expense amount when physicians perform the service in facilities other than their offices. MedPAC recommends, however, that a service-by-service approach be used to decide which services are subject to this site-of-service differential, rather than applying the same decision to entire groups of services. Services generally recognized as inappropriate to perform in a physician's office should be paid at the lower facility practice expense level. In refining practice expense payments, participants with a wide variety of relevant expertise should be included in the process.

To make the professional liability component of the fee schedule resource based, payments should reflect the risk of a professional liability claim in providing each service.

### **Establishing new prospective payment systems in the fee-for-service program**

The BBA established new prospective payment systems for post-acute care providers—skilled nursing facilities, home health agencies, and rehabilitation hospitals—and for services provided in hospital outpatient departments. Payments to these providers had previously been made on the basis of facilities' costs—and also charges in the case of hospital outpatient departments—subject to certain limits. Under the new prospective payment systems, fixed predetermined payments will be made for a specified set of services.

For skilled nursing facilities, a three-year phase-in of the PPS began in July 1998. Implementation of the PPS for home health agencies, originally scheduled for October 1999, was delayed for one year by the Omnibus Consolidated Emergency Supplemental Appropriations Act of 1998. The PPS for rehabilitation hospitals is scheduled to be implemented in October 2000. The prospective payment systems for hospital outpatient departments was originally scheduled to be implemented in January 1999 but has been

delayed.

The new prospective payment systems will reduce uncertainty for both providers and policymakers and will encourage providers to deliver care efficiently. Prospective payments will also allow policymakers to compare rates across settings more directly, which will make it easier to set payment rates that vary according to the services provided and not simply their location. Policymakers will need to monitor the quality of and access to care to ensure that providers do not react to the new systems by stinting on care, rather than improving efficiency.

*Developing new payment systems for post-acute care providers.* The BBA mandated substantial changes in Medicare payment policy for providers of post-acute care. To guide the development of consistent payment policies across post-acute care settings, MedPAC recommends that common data elements be collected to help identify and quantify the overlap of patients treated and services provided. Further, it is important to put in place quality monitoring systems in each setting to ensure that adequate care is provided in the appropriate site. We also support research and demonstrations to assess the potential of alternative classification systems for use across settings to make payments for like services more comparable.

The Commission has several recommendations intended to improve the PPS for skilled nursing facilities. More work is needed to refine the classification system used in the PPS for skilled nursing facilities, particularly in its ability to predict the costs of nontherapy ancillary services. Alternative ways of grouping rehabilitation services provided in SNFs may also be called for to reduce reliance on measurements of rehabilitation time. A method for updating the relative weights that determine how much facilities are paid for each type of patient is crucial as the system and the types of services provided change over time. In general, as better data become available with the new system, distortions in the base payment rates due to imperfections in the initial data and measures used should be detected and corrected. To avoid future problems, facilities must be accountable for accurately assessing patients' needs and reporting the data used to determine payment for each case. Finally, payments should be adjusted for geographic differences in labor prices using wage data from SNFs, rather than hospitals, to make them more equitable among providers.

The BBA put in place an interim payment system (IPS) to govern payments to home health agencies until a prospective payment system was developed. The IPS was the subject of a great deal of controversy in the year following its enactment. This controversy stemmed, in part, from the use of payment policy as a vehicle for curbing the rapidly rising cost of a benefit that was poorly defined. Although the debate appears to

have subsided, at least temporarily, with recent changes to the IPS, MedPAC believes that more fundamental changes are necessary even as a new payment system is being developed. We urge the Congress, in consultation with the Secretary, to enact clearer eligibility and coverage guidelines for Medicare home health services. To better understand the content of home health visits, agencies' bills should describe the specific services provided. Moreover, we recommend that an independent assessment of need be conducted for Medicare beneficiaries who receive extensive home health care to ensure that care is appropriately coordinated and suits the needs of the patient. Finally, modest beneficiary cost sharing should be introduced for home health services; copayments should be subject to an annual limit, and low-income beneficiaries should be exempt from this requirement.

As systems for rehabilitation facilities are developed, a number of crucial decisions must be made. Among them is the unit of payment. MedPAC recommends that a per-discharge mechanism be adopted for rehabilitation services. A system currently exists that with some modifications could serve as a basis for such an approach. We also recommend that, in choosing a patient classification methodology for a long-term hospital PPS, HCFA consider not only per diem but also existing and potential per-discharge approaches.

*Modifying payment for services provided in ambulatory care facilities.* Spending for facility-based ambulatory care services has grown substantially since the early 1980s, in part because a combination of financial incentives and technological advances encouraged shifting of services that once were provided exclusively in the inpatient setting to hospital outpatient departments (OPDs), ambulatory surgical centers (ASCs), and physicians' offices. Medicare pays for many of these services differently according to where they are provided.

As required by the BBA, the Secretary has proposed a new payment system for hospital outpatient services. MedPAC recommends these changes be closely monitored to ensure that beneficiary access to appropriate care is not compromised in the face of substantial reductions in payments to hospital OPDs. In addition, payments should reflect the higher costs of treating certain types of patients. In the absence of adequate patient-level indicators, facility-level adjustments may be required for the time being. We are also concerned that loosening guidelines for determining whether a procedure is eligible for coverage in an ASC may lead to inappropriate changes in the pattern of service provision across ambulatory settings.

Although the BBA provided for a gradual reduction in the amount of beneficiary coinsurance for services provided in hospital outpatient departments, it will be years

before that amount is reduced to a level comparable with that for similar Medicare-covered services furnished in ASCs or physicians' offices. MedPAC recommends accelerating the reduction in the outpatient coinsurance, to be funded by increased program spending rather than by further reductions in hospital payments.

The Commission makes several recommendations that apply to payment for ambulatory care in general. Consistent with the way that Medicare pays for physicians' services, the unit of payment should be the individual service—that is, the primary service and the ancillary supplies and services integral to it—rather than a larger bundle of services. Accordingly, the relative cost of the individual service should determine payment, rather than costs for groups of services taken together. When payment rates are set, the pattern of services and costs across ambulatory settings should be taken into account. Moreover, a single update mechanism that links updates to spending growth across all ambulatory care settings should be applied to the payment rates for each type of provider.

### **Improving the quality of dialysis services**

The BBA required the Secretary to develop and implement methods to measure and report the quality of dialysis services. MedPAC is studying the quality of care provided

to beneficiaries with renal failure and will comment on this topic in its June Report to the Congress. In March, the Commission recommended updating the composite rate for outpatient dialysis services. The dialysis industry has been profitable, and firms continue to enter the market despite the lack of a significant update in the composite rate since it was established in 1983. The Commission's analysis indicates, however, that costs have been approaching payments in recent years. We are concerned that further increases in dialysis costs relative to the payment rate may cause quality to deteriorate.

## **Conclusion**

In just over a decade, the first members of the baby-boom generation will become eligible for Medicare, and policymakers have appropriately focused significant attention on how to address Medicare's future fiscal pressures. But Medicare also faces challenges in the short run as HCFA continues to implement the BBA, developments unfold in the market for health care, and new technologies and treatments emerge.

These short-run challenges are inevitable because Medicare is an extraordinarily large and complex program. The program has almost 40 million beneficiaries, and it makes payments to hundreds of thousands of providers who deliver tens of thousands of different kinds of health care services and supplies. Medicare's payment policies both

influence and are influenced by the larger health system and market for health services in which the program operates. Therefore, Medicare's payment policies must continue evolving to ensure that beneficiaries have access to high quality, medically necessary care across the country.

To assist the Congress and HCFA in meeting this objective, MedPAC will continue to monitor Medicare beneficiaries' access to health care and will examine what can be done to improve quality in both Medicare+Choice and in the traditional fee-for-service program. The Commission will track developments as the Medicare+Choice program matures and will look at the availability of plans, the impact of risk adjustment, and other payment policies. MedPAC will continue to analyze fee-for-service payment policies in a broad context that takes into account the implications of providing health care services in an increasing variety of settings. This work will look at what constitutes an appropriate unit of payment and how payments are currently updated using different methods. Finally, the Commission will continue to study the delivery of services in the broader health care market to determine whether strategies that have evolved in private markets can be used to improve Medicare policy.